TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-16-2444-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted.

Amount in Dispute: $124.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2016	Omeprazole, Duloxetine HCL	$124.80	$124.80

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out the guidelines for pharmacy services not subject to a certified network.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - D20 – Not authorized
   - D03- Reviewed and denied by carrier or TPA
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

- 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Issues

1. Was preauthorization required?
2. Was a retrospective review found?
3. What is the applicable rule that pertains to reimbursement?
4. Based on applicable fee schedule is payment due?

Findings

1. The insurance carrier denied disputed service, Omeprazole, with claim adjustment reason code D20 – Not authorized." 28 Texas Administrative Code §134.530 (b) states, Preauthorization for claims subject to the Division's closed formulary.

> (1) Preauthorization is only required for:
>
> (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
>
> (B) any compound that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates; and
>
> (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

The service in dispute Omeprazole, has a "Status – Y" per ODG Appendix A. Prior authorization was not required. The carrier's denial is not supported.

2. The insurance carrier denied the other disputed service Duloxetine HCL, with claim adjustment reason code D03 – "Reviewed and denied by carrier or TPA." 28 Texas Administrative Code §134.530(d)(3) states,

> Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (g) of this section.

Evidence of a retrospective review dated October 13, 2015 was found to support the respondent's denial. However, the date of service in dispute is January 6, 2016. The Division finds the requirements of Rule 134.503(d)(3) were not met as the submitted review is prospective to the date of service in dispute. The carrier's denial is not supported.

3. 28 Texas Administrative Code §134.503(c)(1)states,

> The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
>
> (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
>
> (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
>
> (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection

The total allowable reimbursement will be calculated based on the submitted NDC and reported units as follows:

Date of Service	Prescribed Medication	Units	Amount billed	MAR (AWP) x units x 1.25 + $4.00
January 6, 2016	Omerprazole	30	$37.30	4.44864 x 30 x 1.25 + $4.00 = $170.82
January 6, 2016	Duloxetine HCL	60	$87.50	7.85156 x 60 x 1.25 + $4.00 = $592.87
			Total	$763.69

4. The total allowable based on the submitted claims' NDC numbers and units dispensed, is $763.69. The requestor is seeking $124.80. Pursuant to applicable fee guidelines this amount is allowed.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $124.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $124.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 19, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.